

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Pleasant Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5501 Verulam Cincinnati, OH 45213	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on record review, staff interviews, and policy review, the facility failed to ensure residents were free from delay of care and treatments as ordered by physicians. This affected one (#69) resident of three reviewed for quality of care. The facility census was 77.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included sepsis with methicillin resistant staphylococcus aureus (MRSA), chronic obstructive pulmonary disease (COPD), and hepatitis C, and</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. Section O (special treatments, procedures, and programs) revealed Resident #69 had intravenous (IV) medications.</p> <p>Review of the Continuity of Care (COC) (hospital discharge paperwork) dated 07/22/24 revealed Resident #69 was to continue Daptomycin (antibiotic) 500 milligrams (mg) IV via peripheral inserted central catheter (PICC) every 24 hours through 08/29/24, Teflaro (Antibiotic) 600 mg IV every eight hours through 08/29/24, get weekly laboratory (labs) tests on Mondays for basal metabolic panel (BMP), complete blood count (CBC) with differential, and liver function tests (LFTs) and fax all laboratory (lab) results to the Infectious Disease (ID) specialist's office. The resident was to follow up with the ID specialist in three to four weeks and the facility was to call the ID specialist's office with any questions or concerns.</p> <p>Review of a physician order dated 07/22/24 revealed Resident #69 was ordered Teflaro Solution Reconstituted 600 mg IV every eight hours for seven days.</p> <p>Review of the physician order dated 07/23/24 revealed Resident #69 was ordered Daptomycin solution reconstituted 500 mg IV one time a day for seven days.</p> <p>Review of a nurse practitioner (NP) note dated 07/27/24 revealed Resident #69 was admitted to the facility with MRSA bacteremia and would order labs. Medications were reviewed, the resident had a PICC line in his right bicep and was to continue IV antibiotics as directed and follow up with ID specialist as directed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medication administration record (MAR) dated July 2024 revealed Resident #69 missed six out of the 22 physician ordered doses of Teflaro and five out of seven physician ordered doses of Daptomycin.</p> <p>Review of the medical record from July and August 2024 for Resident #69 with the Director of Nursing (DON) revealed no physician order to discontinue the PICC line and no documentation of when the resident's PICC line was removed and by whom. Interview with the DON on 10/03/24 at 12:45 P.M., verified the resident's PICC line was removed without a physician order and the resident missed the doses of his antibiotics.</p> <p>Review of a progress note from the ID specialist's office dated 08/28/24 revealed Resident #69 arrived at the appointment with no PICC line in place, and the resident was unsure when it was removed or if he had been receiving IV antibiotics. The Orders were placed for Daptomycin and Teflaro to be continued through 08/29/24. The office had not received any out-patient monitoring of labs from his nursing facility. The nursing facility was contacted and learned that Resident #69 had not received any IV antibiotics since 08/01/24 when he had an emergency room (ER) visit for a fall. The ID specialist's office was not contacted, and it was unclear why the PICC line was removed. New orders for STAT (right now or immediately) blood cultures needed drawn, PICC line placement, restart Daptomycin 500 mg IV via PICC daily for six weeks, Teflaro 600 mg every eight hours for six weeks, monitor weekly labs (BMP, CBC with diff, and LFTs) and send to the ID specialist's office, an abdominal ultrasound (US) with elastography, and follow-up in three weeks.</p> <p>Review of the progress note from the ID specialist's office dated 08/30/24 at 9:46 A.M. revealed an outreach was made to the facility's DON regarding the plan of care for Resident #69 with no answer.</p> <p>Review of the progress note from the ID specialist's office dated 08/30/24 at 2:15 P.M. revealed an outreach was made to the facility and spoke with the DON. Verbal orders were given to the DON for STAT blood cultures, PICC placement, Daptomycin 500 mg IV via PICC daily for six weeks, and Teflaro 600 mg every eight hours for six weeks. The DON verbalized understanding.</p> <p>Review of the progress note from the ID specialist's office dated 08/30/24 at 4:38 P.M. revealed an outreach was made to the facility, which revealed the physician's orders had not been placed for Resident #69.</p> <p>Review of the progress note from the ID specialist's office dated 09/05/24 at 4:47 P.M. revealed no blood cultures had been received with several outreach attempts to the facility with no answer.</p> <p>Review of the progress note from the ID specialist's office dated 09/06/24 at 4:00 P.M. revealed an outreach was made to the facility, which revealed blood cultures were not collected for Resident #69.</p> <p>Review of the progress note from ID specialist's office dated 09/09/24 at 2:39 P.M. revealed an outreach was made to the DON and she indicated blood cultures were collected but the results were not in yet. DON indicated the IV antibiotics had not been started yet related to not having the blood culture results.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note from ID specialist's office dated 09/09/24 at 3:55 P.M. revealed an outreach was made to the DON. Verbal orders were given for PICC placement and to start dual IV antibiotics (Daptomycin and Teflaro). The DON verified and assured the specialist's office this would happen as soon as possible.</p> <p>Review of the progress note from ID specialist's office dated 09/10/24 at 4:53 P.M. revealed an outreach was made to the facility where they revealed Resident #69's PICC had just been placed and was awaiting an X-ray confirmation.</p> <p>Review of the MAR dated September 2024 revealed Resident #69 missed six doses of Teflaro and three doses of Daptomycin.</p> <p>Review of the MAR dated October 2024 revealed Resident #69 missed three additional doses of Daptomycin.</p> <p>Interview on 10/03/24 at 10:30 A.M. with Registered Nurse (RN) #35 from the ID specialist's office revealed Resident #69's antibiotics should have been continued through 08/29/24 and not have never been stopped in July. RN #35 revealed Resident #69 was seen in their office on 08/28/24, where they learned the resident had not continued his two IV antibiotics and his PICC line had been removed without a physician's order. RN #35 revealed communication between the nursing facility and their office had been a nightmare. RN #35 also stated the facility was not following orders per the physician in a timely manner.</p> <p>Interview on 10/03/24 at 11:29 A.M. with Regional Corporate Nurse (RCN) #36 verified there was a delay of care to Resident #69 related to orders received from his 08/28/24 ID specialist appointment because the orders were not initiated until 09/09/24. RCN #36 also verified it was the nursing staff's responsibility to follow up with outside providers within 24-48 hours if paperwork was not returned with the resident.</p> <p>Interview on 10/03/24 at 12:06 P.M. with the DON revealed Resident #69's IV antibiotics were not started in September because she was informed by the ID specialist's office that the blood cultures had to be drawn first. The DON reported there were issues with getting the STAT labs completed.</p> <p>Review of the facility policy titled, Physician Orders, dated 10/08/24 revealed the purpose of the policy was to provide orders as determined by the licensee's scope of practice. The provider may write the order in the medical record or may enter an electronic order. The nurse that received the physician order will be responsible for executing the order or providing for the safe hand-off to the next nurse.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157798.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Review of the medical record, staff interviews, observations, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected one (#69) of three residents reviewed for medication administration. The facility census was 77.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included sepsis with methicillin resistant staphylococcus aureus (MRSA), chronic obstructive pulmonary disease (COPD), chronic hepatitis C, and emphysema.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12.</p> <p>Review of section O (special treatments, procedures, and programs) revealed Resident #69 had intravenous (IV) medications.</p> <p>Review of the physician order dated 07/22/24 revealed Resident #69 was ordered Teflaro (antibiotic) IV Solution Reconstituted 600 milligrams (mg), use 600 mg IV every eight hours for seven days.</p> <p>Review of the pharmacy delivery manifest dated 07/23/24 at 8:03 P.M. revealed Resident #69 had six doses of Teflaro delivered and four doses Daptomycin delivered.</p> <p>Review of the physician order dated 07/23/24 revealed Resident #69 was ordered Daptomycin IV solution reconstituted 500 mg, use 500 mg IV one time a day for seven days.</p> <p>Review of the pharmacy delivery manifest dated 07/24/24 at 6:59 P.M. revealed Resident #69 had six doses of Teflaro delivered.</p> <p>Review of the pharmacy delivery manifest dated 07/26/24 at 8:15 P.M. revealed Resident #69 had three doses of Daptomycin delivered.</p> <p>Review of the pharmacy delivery manifest dated 07/27/24 at 8:42 A.M. revealed Resident #69 had nine doses of Teflaro delivered.</p> <p>Review of the medication administration record (MAR) dated July 2024 revealed Resident #69 missed six out of 22 doses of Teflaro on 07/22/24, 07/23/24, and 07/24/24 morning and afternoon dose. Resident #69 missed five out of seven doses of Daptomycin on 07/23/24, 07/24/24, 07/25/24, 07/26/24, and 07/27/24.</p> <p>Review of the physician order dated 09/09/24 revealed Resident #69 was ordered Daptomycin IV solution reconstituted 500 mg, use 500 mg IV every 24 hours until 10/21/24.</p> <p>Review of the pharmacy delivery manifest dated 09/10/24 at 9:13 A.M. revealed Resident #69 had four doses of Daptomycin delivered</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the pharmacy delivery manifest dated 09/14/24 at 9:08 A.M. revealed Resident #69 had three doses of Daptomycin delivered.</p> <p>Review of the pharmacy delivery manifest dated 09/16/24 at 8:29 P.M. revealed Resident #69 had two doses of Daptomycin delivered.</p> <p>Review of the pharmacy delivery manifest dated 09/19/24 at 9:20 A.M. revealed Resident #69 had three doses of Daptomycin delivered.</p> <p>Review of the MAR dated September 2024 revealed Resident #69 missed three doses of Daptomycin on 09/09/24, 09/10/24, and 09/30/24.</p> <p>Interview on 10/02/24 at 2:32 P.M. with Pharmacist #60 revealed the delivery of Resident #69's IV antibiotics for the month of July and September. Pharmacist #60 reported there was a mess up on their end regarding Daptomycin order, which caused the facility to not receive any more doses after 09/19/24. Pharmacist #60 reported the person who processed the refills on 09/19/24 accidentally put the end date as 09/21/24 instead of 10/21/24.</p> <p>Interview on 10/02/24 at 3:49 P.M. with Registered Nurse (RN) #30 verified Daptomycin was still an active order, but the facility did not have this medication available and had not outreached to the pharmacy to inquire where the medications were.</p> <p>Observation on 10/02/24 at 3:50 P.M. revealed the medication stock room had no IV Daptomycin available for Resident #69.</p> <p>Interview on 10/03/24 at 11:29 A.M. with Regional Corporate Nurse (RCN) #36 verified missed doses in July 2024 for IV antibiotics and verified missed doses in September.</p> <p>Review of the facility policy titled, Medication Administration, revealed the purpose of the policy was to provide guidelines for general medication administration to be provided by personnel recognized as legally able to administer. Staff administer medication only as prescribed by the provider. Licensed or authorized personnel may administer prescribed medication.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157798.</p>		